"pockets food," etc. Inspect the mouth for abnormalities that could contribute to chewing or swallowing problems or mouth pain.

Coding: Check all that apply. If none apply, check *NONE OF ABOVE*.

K2. Height and Weight (30-day look back)

Intent: To record a current height and weight in order to monitor nutrition and hydration status over time; also, to provide a mechanism for monitoring stability of weight over time. For example, a resident who has had edema can have an intended and expected weight loss as a result of taking a diuretic. Or weight loss could be the result of poor intake, or adequate intake accompanied by recent participation in a fitness program.

a. Height

Process: **New Admissions** - Measure height in inches.

Current Resident - Check the clinical records. If the last height recorded was more than one year ago, measure the resident's height again.

Coding: Round height upward to the nearest whole inch. Measure height consistently over time in accord with standard facility practice (shoes off, etc.)

b. Weight

Process: Check the clinical records. If the last recorded weight was taken more than one month ago or previous weight is not available, weigh the resident again. If the resident has experienced a decline in intake at meals, snacks, or fluid intake, weigh the resident again. If the resident's weight was taken more than once during the preceding month, record the most recent weight.

Coding: Round weight upward to the nearest whole pound. Measure weight consistently over time in accord with standard facility practice (after voiding, before meal, etc.). There may be circumstances when a resident cannot be weighed, for example: extreme pain, immobility, or risk of pathological fractures. If, as a matter of professional judgment, a resident cannot be weighed, use the standard no-information code (**-**). Document rationale on resident's record.

K3. Weight Change (30 and 180-day look backs)

Intent: To record variations in the resident's weight over time.

a. Weight Loss

Definition: **Weight Loss in Percentages** (e.g., 5% or more in last 30 days, or 10% or more in last 180 days).

Process: **New Admission** - Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current Resident - Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: Code "**0**" for No or "**1**" for Yes. Round weight upward to the nearest whole pound. If there is no weight to compare to, enter the unknown code (**-**).

b. Weight Gain

Definition: **Weight Gain in Percentages** (i.e., 5% or more in last 30 days, or 10% or more in up to the last 180 days). Although height and weight are rounded up, percentage is not; e.g., 4.5% should not be rounded to 5%.

Process: **New Admission** - Ask the resident or family about weight changes over the last 30 and 180 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

Current Resident - Review the clinical records and compare current weight with weights of 30 and 180 days ago. Calculate weight gain during the specified time periods.

Coding: Code "**0**" for No or "**1**" for Yes. If there is no weight to compare to, enter a dash (**-**).

Clarifications:
- ◆ The first step in calculating percent weight gain or loss is to obtain the weights for the 30-day and 180-day time periods from the resident's clinical record. The calculation is as follows:

  1. Start with the resident's weight from 30 days ago and multiply it by the proportion (0.05). If the resident has gained or lost more than this 5%, code a "1" for Yes.

  2. Start with the resident's weight from 180 days ago and multiply it by the proportion (0.10). If the resident has gained or lost more than this 10%, code a "1" for Yes.

  3. Residents experiencing a 7½% weight change (gain or loss) 90 days ago must be evaluated to determine how much of the 7½% weight change occurred over the last 30 days.

- There are no specific regulations that address the desirable weight and time frames for weight gain or weight loss. However, there is some general information in the interpretive guidelines and in the Nutritional RAP that may provide guidance in this area. The amount of weight gain or loss is reflective of individual differences. Guidelines related to acceptable parameters of weight gain and loss are addressed in the OBRA regulations at 42 CFR 483.25, nutrition (F325 and F 326) and 483.20(b)2(xi), resident assessment nutritional status and requirements (F 272), which corresponds to the MDS 2.0 Section K, Oral/Nutritional status.

  The parameters for weight loss identified in the guidelines referenced above are:

  1 month 5% significant >5% severe

  3 months 7.5% significant >7.5% severe

  6 months 10% significant >10% severe

  The measurement of weight is a guide in determining nutritional status. Therefore, the evaluation of the significance of weight gain or loss over a specific time frame is a crucial part of the assessment process.

  However, if the resident is losing/gaining a significant amount of weight, the facility should not wait for the 30 or 180-day timeframe to address the problem. Weight changes of 5% in one month, 7.5% in three months, or 10% in six months should prompt a thorough assessment of the resident's nutritional status. For example, a 10% loss/gain within 4 months should also be coded here, and carefully evaluated. An adequate assessment should result in a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's needs and expressed desires.

K4. Nutritional Problems (7-day look back)

Intent: To identify specific problems, conditions, and risk factors for functional decline present in the last seven days that affect or could affect the resident's health or functional status. Such problems can often be reversed and the resident can improve.

Definition:

a. **Complains About the Taste of Many Foods** - The sense of taste can change as a result of health conditions or medications. Also, complaints can be culturally based - e.g., someone used to eating spicy foods may find nursing facility meals bland.

b. **Regular or Repetitive Complaints of Hunger** - On most days (at least 2 out of 3), resident asks for more food or repetitively complains of feeling hungry (even after eating a meal).

c. **Leaves 25% or More of Food Uneaten at Most Meals** - Eats less than 75 percent of food (even when substitutes are offered) at least 2 out of 3 meals a day. This assumes the resident is receiving the proper amount of food to meet their daily requirements and not excessive amounts above and beyond what they could be expected to consume.

d. *NONE OF ABOVE*

Process: Consult resident's records (including current nursing care plan), dietary/fluid intake flow sheets, and dietary progress notes/assessments. Consult with direct-care staff, dietary staff and the consulting dietitian. Ask the resident if he or she experienced any of these symptoms in the last seven days. Sometimes a resident will not complain to staff members because he or she attributes symptoms to "old age." Therefore, it is important to ask the resident directly. Observe the resident while eating. If he or she leaves food or picks at it, ask, "Why are you not eating? Would you eat if something else was offered?" Observe if resident winces or makes faces while eating. **NOTE:** Facilities are required to offer substitutions when residents do not eat or like the food being served. Observe whether or not residents have refused offers for substitute meals.

Coding: Check all conditions that apply. If no conditions apply, check *NONE OF ABOVE.*

K5. Nutritional Approaches (7-day look back)

Definition:

a. **Parenteral/IV** - Intravenous (IV) fluids or hyperalimentation, including total parenteral nutrition, given continuously or intermittently. This category also includes administration of fluids via IV lines with fluids running at KVO (Keep Vein Open), or via heparin locks. This category does not include administration of IV medications. If the resident receives IV medications, check Item P1ac in "Special Treatments and Procedures." Do not include IV fluids that were administered as a routine part of an operative procedure or recovery room stay. Do not include insulin administered intravenously.

b. **Feeding Tube** - Presence of any type of tube that can deliver food/nutritional substances/fluids/medications directly into the gastrointestinal system. Examples include, but are not limited to, nasogastric tubes, gastrostomy tubes, jejunostomy tubes, percutaneous endoscopic gastrostomy (PEG) tube.

c. **Mechanically Altered Diet -** A diet specifically prepared to alter the consistency of food in order to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. A mechanically altered diet should not automatically be considered a therapeutic diet. Determine whether or not the therapeutic diet should be coded based on the definition in Item K5e below.

d. **Syringe (Oral Feeding)** - Use of syringe to deliver liquid or pureed nourishment directly into the mouth. All efforts should be made to utilize other feeding methods (e.g., rubber tipped spoon) as this can result in lowered resident dignity.

e. **Therapeutic Diet -** A diet ordered to manage problematic health conditions. Examples include calorie-specific, low-salt, low-fat lactose, no added sugar, and supplements during meals.

f. **Dietary Supplement Between Meals** - Any type of dietary supplement provided between scheduled meals (e.g., high protein/calorie shake, or 3 p.m. snack for resident who receives q.a.m. dose of NPH insulin). Do not include snacks that everyone receives as part of the unit's daily routine.

g. **Plate Guard, Stabilized Built-Up Utensils, Etc.** - Any type of specialized, altered, or adaptive equipment to facilitate the resident's involvement in self-performance of eating.

h. **On Planned Weight Change Program** - Resident is receiving a program of which the documented purpose and goal are to facilitate weight gain or loss (e.g., double portions; high calorie supplements; reduced calories; 10 grams fat).

i. ***NONE OF ABOVE (Not Used on the MPAF)***

Coding: Check all that apply. If none apply, check *NONE OF ABOVE*.

Clarification:
- If the resident receives fluids by hypodermoclysis and subcutaneous ports in hydration therapy, code these nutritional approaches in this item. The term parenteral therapy means "introduction of a substance (especially nutritive material) into the body by means other than the intestinal tract (e.g., subcutaneous, intravenous)." If the resident receives fluids via these modalities, also code Items K6a and b, which refer to the caloric and fluid intake the resident received in the last 7 days. Additives such as electrolytes and insulin, which are added to the resident's parenteral nutrition, should be counted as medications and documented in Section O1, but NOT in P1ac.

K6. Parenteral or Enteral Intake (7-day look back)

Skip to Section L on the MDS if neither Item K5a nor K5b is checked.

Intent: To record the proportion of calories received and the average fluid intake, through parenteral or tube feeding in the last seven days.

a. PROPORTION OF TOTAL CALORIES

Definition: **Proportion of Total Calories Received** - The proportion of all calories ingested during the last seven days that the resident **actually received** (not ordered) by parenteral or tube feedings. Determined by calorie count.

Process: Review Intake record. If the resident took no food or fluids by mouth, or took just sips of fluid, stop here and code "4" (76%-100%). If the resident had more substantial oral intake than this, consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

Coding: Code for the best response:

0. None
1. 1% to 25%
2. 26% to 50%
3. 51% to 75%
4. 76% to 100%

Example of Calculation for Proportion of Total Calories from IV or Tube Feeding

Mr. H has had a feeding tube since his surgery. He is currently more alert, and feeling much better. He is very motivated to have the tube removed. He has been taking soft solids by mouth, but only in small to medium amounts. For the past week he has been receiving tube feedings for nutritional supplementation. As his oral intake improves, the amount received by tube will decrease. The dietitian has totaled his calories per day as follows:

Step #1:

	Oral		Tube
Sun.	500	+	2000
Mon.	250	+	2250
Tues.	250	+	2250
Wed.	350	+	2250
Thurs.	500	+	2000
Fri.	800	+	800
Sat.	800	+	1800
TOTAL	3450	+	14350

Step #2: Total calories = 3450 + 14350 = 17800

Step #3: Calculate percentage of total calories by tube feeding.

14350/17800 = .806 X 100 = 80.6%

Step #4: Code "4" for 76% to 100%

b. AVERAGE FLUID INTAKE

Definition: Average fluid intake per day by IV or tube feeding in last seven days refers to the actual amount of fluid the resident received by these modes (not the amount ordered).

Process: Review the Intake and Output record from the last seven days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Also include the water used to flush as well as the "free water" in the tube feeding (based upon the percent of water in the specific enteral formula). The amount of heparinized saline solution used to flush a heparin lock **is not** included in the average fluid intake calculation, while the amount of fluid in an IV piggyback solution **is** included in the calculation. Divide the week's total fluid intake by 7. This will give you the average of fluid intake per day.

Coding: Code for the average number of cc's of fluid the resident received per day by IV or tube feeding. Record what was actually received by the resident, not what was ordered.

Codes:
0. None
1. 1 to 500 cc/day
2. 501 to 1000 cc/day
3. 1001 to 1500 cc/day
4. 1501 to 2000 cc/day
5. 2001 or more cc/day

Example of Calculation for Average Daily Fluid Intake

Ms. A has swallowing difficulties secondary to Huntington's disease. She is able to take oral fluids by mouth with supervision, but not enough to maintain hydration. She received the following daily fluid totals by supplemental tube feedings (including water, prepared nutritional supplements, juices) during the last 7 days.

Step #1:	Sun.	1250 cc
	Mon.	775 cc
	Tues.	925 cc
	Wed.	1200 cc
	Thurs.	1200 cc
	Fri.	1200 cc
	Sat.	1000 cc
	TOTAL	7550 cc

Step #2: 7550 divided by 7 = 1078.6 cc

Step #3: Code "3" for 1001 to 1500 cc/day

Clarifications:

- The basic TPN solution itself (that is, the protein/carbohydrate mixture or a fat emulsion) is not counted as a medication. The use of TPN is coded in Item K6a. When medications such as electrolytes, vitamins, or insulin have been added to the TPN solution, they are considered medications and should be coded in O1.
- The amount of heparinized saline solution used to flush a heparin lock is not included in the average fluid intake calculation. The amount of fluid in an IV piggyback solution is included in the calculation.

SECTION L. ORAL/DENTAL STATUS

L1. Oral Status and Disease Prevention (7-day look back)

Intent: To document the resident's oral and dental status as well as any problematic conditions.

a. **Debris (Soft, Easily Movable Substances) Present in Mouth Prior to Going to Bed at Night**

b. **Has Dentures or Removable Bridge**

c. **Some/All Natural Teeth Lost-Does Not Have or Does Not Use Dentures (or Partial Plates)**

d. **Broken, Loose, or Carious Teeth**

e. **Inflamed Gums (Gingiva); Swollen or Bleeding Gums; Oral Abcesses; Ulcers or Rashes**

f. **Daily Cleaning of Teeth/Dentures or Daily Mouth Care-by Resident or Staff**

g. ***NONE OF ABOVE***

Definition: **Carious** - Pertains to tooth decay and disintegration (cavities).

Process: Ask the resident, and examine the resident's mouth. Ask direct care staff if they have noticed any problems.

Coding: Check all that apply. If none apply, check *NONE OF ABOVE*.

SECTION M.
SKIN CONDITION

To determine the condition of the resident's skin, identify the presence, stage, type, and number of ulcers, and document other problematic skin conditions. Additionally, to document any skin treatments for active conditions as well as any protective or preventive skin or foot care treatments the resident has received in the last seven days.

M1. Ulcers (due to any cause) (7-day look back)

Intent: To record the number of ulcers/open lesions, of any type at each ulcer stage, on any part of the body.

Definition: A skin ulcer/open lesion can be defined as a local loss of epidermis and variable levels of dermis and subcutaneous tissue, or in the case of Stage 1 pressure ulcers, persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved. Open lesions/sores are skin ulcers that may develop because of injury, circulatory problems, pressure, or in association with other diseases such as syphilis. Rashes without open areas, burns, desensitized skin and surgical wounds are **NOT** coded here, but are included in Item M4.

a. Stage 1. A persistent area of skin redness (without a break in the skin) that does not disappear when pressure is relieved.

b. Stage 2. A partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater.

c. Stage 3. A full thickness of skin is lost, exposing the subcutaneous tissues. Presents as a deep crater with or without undermining adjacent tissue.

d. Stage 4. A full thickness of skin and subcutaneous tissue is lost, exposing muscle or bone.

Process: Review the resident's record and consult with the nurse assistant about the presence of an ulcer/open lesion. Examine the resident and determine the stage and number of any ulcers present. Without a full body check, an ulcer/open lesion can be missed.

Assessing a Stage 1 ulcer/open lesion requires a specially focused assessment for residents with darker skin tones to take into account variations in ebony-colored skin. To recognize Stage 1 ulcers/open lesions in ebony complexions, look for: (1) any change in the feel of the tissue in a high-risk area; (2) any change in the appearance of the skin in high-risk areas, such as the "orange-peel" look; (3) a subtle purplish hue; and (4) extremely dry, crust-like areas that, upon closer examination, are found to cover a tissue break.

Coding: All skin ulcers/open lesions should be coded in this item. Record the number of ulcers/open lesions at each stage on the resident's body, in the last 7 days, regardless of the ulcer/open lesion cause. If necrotic eschar is present, prohibiting accurate staging, code the ulcer/open lesion as Stage "4" until the eschar has been debrided (surgically or mechanically) to allow staging. If there are no ulcers/open lesions at a particular stage, record "0" (zero) in the box provided. If there are more than 9 ulcers/open lesions at any one stage, enter a "9" in the appropriate box.

Clarifications:

- ◆ All problems and lesions present during the current observation period should be documented on the MDS assessment. These items refer to the objective presence of problems or lesions, as observed during the assessment period.

- ◆ Staff should code healing ulcers in the MDS using a reverse-staging protocol. For the MDS assessment, Item M2a, pressure ulcers should be coded in terms of what is seen (i.e., visible tissue). For example, a healing Stage 3 pressure ulcer that has the appearance (i.e., presence of granulation tissue, size, depth, and color) of a Stage 2 pressure ulcer must be coded as a "2". Facilities certainly may adopt the National Pressure Ulcer Advisory Panel (NPUAP) standards in their clinical practice. However, the NPUAP standards cannot be used for coding on the MDS.

- ◆ Debridement of an ulcer merely removes necrotic and decayed tissue to promote healing. The ulcer still exists and may or may not be at the same stage as it was prior to debridement. Good clinical practice dictates that the ulcer be re-examined and re-staged after debridement. Also code treatments as appropriate in Item M5 (Skin Treatments).

- ◆ If, as the result of pressure, a skin shear or tear occurs on a pressure point (e.g., a resident has a skin tear on her sacrum while being pulled up in bed), it should be coded as a Stage 2 ulcer (M1). However, the determination that an ulcer is the result of pressure cannot be made based merely on its location over a pressure point. Instead, a clinician's assessment may be required to determine the ulcer's cause. Using this example, if the resident cannot reposition herself while on her back in bed, it is logical to determine that pressure on the sacrum contributed to the formation of the ulcer, i.e., the resident cannot move independently to relieve the pressure. On the other hand, if the shear or tear occurred over a pressure point, but on a resident who is able to reposition herself, the determination is less likely that pressure on that point was the cause of the ulcer. In either case, Item M1 would be completed, but Item M2a would be completed only if pressure caused the lesion.

Example

Mrs. L has end-stage metastatic cancer and weighs 75 pounds. She has a Stage 3 ulcer over her sacrum and two Stage 1 ulcers over her heels.

Items M1, Ulcers (due to any cause)	Stage	Code
	a. 1	2
	b. 2	0
	c. 3	1
	d. 4	0

Mr. Alaska has five open wounds as a result of frostbite that are not pressure or venous stasis ulcers. Upon examination, these wounds meet the criteria provided in Item M1 (Ulcers) coding definitions: Four ulcers are consistent with Stage 2 ulcer staging and one ulcer appears to be at Stage 3. Assuming that the resident in this scenario has no pressure ulcers, code the resident's condition as follows:

Items M1, Ulcers (due to any cause)	Stage	Code
	a. 1	0
	b. 2	4
	c. 3	1
	d. 4	0

Items M2, Type of Ulcer:
Code "0" (highest stage ulcer is not a pressure ulcer)

Items M4, Other Skin Problems or Lesions Present:
Code Item M4c unless the frostbite wounds are to the foot, then code M6.

Include coding for treatments provided in Items M5 and M6, (Foot Problems and Care) as appropriate.

M2. Type of Ulcer (7-day look back)

Intent: To record the highest stage for two types of ulcers, Pressure and Stasis, that was present in the last 7 days.

Definition: a. **Pressure Ulcer** - Any lesion caused by pressure resulting in damage of underlying tissues. Other terms used to indicate this condition include bedsores and decubitus ulcers.

b. Stasis Ulcer - An open lesion, usually in the lower extremities, caused by decreased blood flow from chronic venous insufficiency; also referred to as a venous ulcer or ulcer related to peripheral vascular disease (PVD).

Process: Review the resident's record. Consult with the physician regarding the cause of the ulcer(s).

Coding: Using the ulcer staging scale in Item M1, record the highest ulcer stage for pressure and stasis ulcers present in the last 7 days. Remember that there are other types of ulcers than the two listed in this item (e.g., ischemic ulcers). An ulcer recorded in Item M1 may not necessarily be recorded in Item M2 (see last example below).

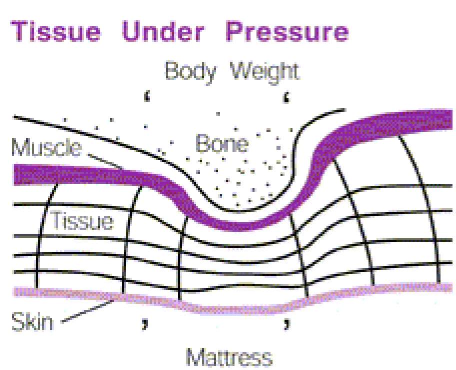
More definitive information concerning pressure ulcers is provided in the AHRQ Guidelines for pressure ulcers in adults at: **http://www.ahrq.gov/consumer/bodysys/edbody6.htm**.

What are Pressure Ulcers?

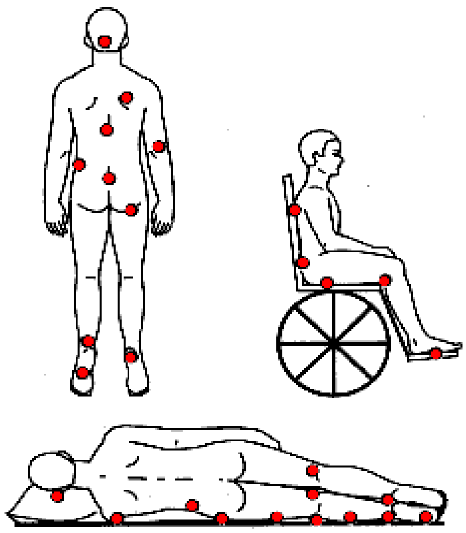
A pressure ulcer is an injury usually caused by unrelieved pressure that damages the skin and underlying tissue. Pressure ulcers are also called decubitus ulcers or bedsores and range in severity from mild (minor skin reddening) to severe (deep craters down to muscle and bone).

Unrelieved pressure on the skin squeezes tiny blood vessels, which supply the skin with nutrients and oxygen. When skin is starved of nutrients and oxygen for too long, the tissue dies and a pressure ulcer forms. The affected area may feel warmer than surrounding tissue. Skin reddening that disappears after pressure is removed is normal and not a pressure ulcer.

Other factors cause pressure ulcers, too. If a person slides down in the bed or chair, blood vessels can stretch or bend and cause pressure ulcers. Even slight rubbing or friction on the skin may cause minor pressure ulcers.



Where Pressure Ulcers Form



Pressure ulcers form where bone causes the greatest force on the skin and tissue, and squeezes them against an outside surface. This may be where bony parts of the body press against other body parts, a mattress, or a chair. In persons who must stay in bed, most pressure ulcers form on the lower back below the waist (sacrum), the hip bone (trochanter), and on the heels. In people in chairs or wheelchairs, the exact spot where pressure ulcers form depends on the sitting position. Pressure ulcers can also form on the knees, ankles, shoulder blades, back of the head, and spine.

Nerves normally tell the body when to move to relieve pressure on the skin. Persons in bed who are unable to move may get pressure ulcers after as little as 1-2 hours. Persons who sit in chairs and who cannot move can get pressure ulcers in even less time because the force on the skin is greater.

NOTE: It is also common for pressure ulcers to form on the ears and scrotum.

The full AHCRP guideline for clinicians can be found at:

http://www.ahcpr.gov/clinic/cpgonline.htm.

Clarifications:

- ◆ In order to code Pressure Ulcers in the case of a blister, the key is to determine if there was a source of pressure that caused the blister. In the presence of moisture, less pressure may be required to develop a pressure ulcer. If, for example, a blister was found in the area of the incontinence brief waist or leg band, pressure from the band may be a likely cause of the blister and the assessor would record the blister as a pressure ulcer. If no source of pressure could be identified, the blister may be evidence of perineal dermatitis caused by excessive urine or stool eroding the epidermis. No pressure is required for perineal dermatitis to occur. If this is the case, the blister would not be recorded as a pressure ulcer, but would be considered a rash. For additional information, refer to: Lyder, C. (1997). Perineal dermatitis in the elderly: A critical review of the literature. Journal of Gerontological Nursing 23(12), 5-10.

- ◆ If there is persistent redness without a break in the skin that does not disappear when pressure is relieved, the problem should be recorded as a Stage 1 ulcer (M1). Less pressure is needed for a pressure ulcer to form when the skin is soiled with urine and/or feces. <u>If the resident is unable to move, or does not move to relieve pressure on the skin, then pressure is very likely to have helped form the ulcer.</u> Item M1a should be coded as "1" and M2a should be coded for the highest stage. In addition, if this is a situation where there is redness from pressure in combination with a contact rash from incontinence, especially if the resident was wet long enough to develop the rash, code Item M2a (pressure ulcer for the highest stage). If the resident's mobility status is not impaired (i.e., they can move to relieve pressure on the skin) and the redness is not likely due to pressure, do not code Item M2a. Code the condition in M4, Other Skin Problems or Lesions Present.

Example

Mr. C has diabetes and poor circulation to his lower extremities. Last month Mr. C spent 2 weeks in the hospital where he had a left below the knee amputation (BKA) for treatment of a gangrenous foot. His hospital course was complicated by delirium (acute confusion) and he spent most of his time on bed rest. Nurses remarked that he would only stay lying on his back. He had only an egg crate mattress on his bed to relieve pressure. A water mattress and air mattress were both tried but aggravated his agitation. He was readmitted to the nursing facility 3 days ago with a Stage II pressure ulcer over his sacrum and a Stage I pressure ulcer over his right heel and both elbows. No other ulcers were present.

Items M1, Ulcers (due to any cause)	**Code (# at stage)**
a. Stage 1	3
b. Stage 2	1
c. Stage 3	0
d. Stage 4	0

Items M2, Type of Ulcer	**Code (highest stage)**
a. Pressure Ulcer	2
b. Stasis Ulcer	0

***Rationale for coding*:** Mr. C has 4 pressure ulcers, the highest stage of which is Stage 2.

Mrs. B has a blockage in the arteries of her right leg causing impaired arterial circulation to her right foot (ischemia). She has 1 ulcer, a Stage 3 ulcer on the dorsal surface (top) of her right foot.

Items M1, Ulcer (due to any cause)	**Code (# at Stage)**
a. Stage 1	0
b. Stage 2	0
c. Stage 3	1
d. Stage 4	0

Items M2, Type of Ulcer	**Code (highest stage)**
a. Pressure ulcer	0
b. Stasis ulcer	0

Items M4, Other Skin Problems or Lesions Present

c. Open lesions other than pressure or stasis ulcers, rashes, cuts (e.g., cancer lesions)

***Rationale for coding*:** Mrs. B's ulcer is an ischemic ulcer rather than caused by pressure or venous stasis.

M3. History of Resolved/Cured Ulcers (90 days ago)

Intent: To determine if the resident previously had an ulcer that was resolved or cured during the past 90 days. Identification of this condition is important because it places the resident at risk for development of subsequent ulcers.

Process: Review clinical records, including the last Quarterly or Medicare PPS assessment.

Coding: Code "**0**" for No or "**1**" for Yes.

M4. Other Skin Problems or Lesions Present (7-day look back)

Intent: To document the presence of skin problems, ulcers, (other than pressure or stasis ulcers) and conditions that are risk factors for more serious problems.

Definition:

a. Abrasions, Bruises - Includes skin scrapes, skin shears, <u>skin tears not penetrating to subcutaneous tissue</u> (also see M4f), ecchymoses, localized areas of swelling, tenderness and discoloration.

b. Burns (Second or Third Degree) - Includes burns from any cause (e.g., heat, chemicals) in any stage of healing. This category does not include first degree burns (changes in skin color only).

c. Open Lesions/Sores Other Than Pressure or Stasis Ulcers, Rashes, Cuts (e.g. cancer lesions) - A local loss of epidermis and variable levels of dermis and subcutaneous tissue. This open sore may develop because of injury or in association with other diseases such as syphilis. Do NOT code skin tears or cuts here (see also M4a or M4f).

d. Rashes (e.g., intertrigo, exzema, drug rash, heat rash, herpes zoster) - Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (e.g., heat, drugs, bacteria, viruses, contact with irritating substances such as urine or detergents, allergies, shingles, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

e. Skin Desensitized to Pain or Pressure - The resident is unable to perceive sensations of pain or pressure.

Review the resident's record for documentation of impairment of this type. An obvious example of a resident with this problem is someone who is comatose. Other residents at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new, disposable safety pin or wooden "orange stick" (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.

- Ask the resident to close his or her eyes. If the resident cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.

- Lightly press the pointed end of the pin or stick against the resident's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the resident's arms, trunk, and legs. Ask the resident to report if the sensation is "sharp" or "dull."

- Compare the sensations in symmetrical areas on both sides of the body.

- If the resident is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.

- For residents who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (e.g., wincing, grimacing, surprise), body motions (e.g., pulling the limb away, pushing the examiner) or sounds (e.g., "Ouch!") to determine if they can feel pain.

- Do not use pins with agitated or restless residents. Abrupt movements can cause injury.

f. Skin Tears or Cuts (Other Than Surgery) - Any traumatic break in the <u>skin penetrating to subcutaneous tissue</u>. Examples include skin tears, skin shears, lacerations, etc. Code skin tears or cuts that do not penetrate to the subcutaneous tissue in M4a.

g. Surgical Wounds - Includes healing and non-healing, open or closed surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites, stomas, or lacerations that require suturing or butterfly closure as surgical wounds.

h. ***NONE OF ABOVE***

Process: Ask the resident if he or she has any problem areas. Examine the resident. Ask the nurse assistant. Review the resident's record.

Coding: Determine the proper response for each skin condition identified in the assessment. Multiple items may be checked only when coding for multiple skin conditions. For example, a skin tear can be coded in either M4a or M4f, not both. Pressure or stasis ulcers coded in M2 should **NOT** be coded here. If there is no evidence of such problems in the last seven days, check *NONE OF ABOVE.*

Clarification:
- ◆ It may be difficult to distinguish between an abrasion and a skin tear/shear if you did not witness the injury. Use your best clinical judgment to code the wound.

M5. Skin Treatments (7-day look back)

Intent: To document any specific or generic skin treatments the resident has received in the past seven days.

Definition:

a. Pressure Relieving Device(s) for Chair - Includes gel, air (e.g., Roho), or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

b. Pressure Relieving Device(s) for Bed - Includes air fluidized, low air loss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category.

c. Turning/Repositioning Program - Includes a continuous, consistent program for changing the resident's position and realigning the body.

d. Nutrition or Hydration Intervention to Manage Skin Problems - Dietary measures received by the resident for the purpose of preventing or treating specific skin conditions - e.g., wheat-free diet to prevent allergic dermatitis, high calorie diet with added supplements to prevent skin breakdown, high protein supplements for wound healing. Vitamins and minerals, such as Vitamin C and Zinc, which are used to mange a potential or active skin problem, should be coded here.

e. Ulcer Care - Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

f. Surgical Wound Care - Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of antimicrobial ointments, application of dressings of any type, suture removal, and warm soaks or heat application.

g. Application of Dressings (With or Without Topical Medications) Other Than to Feet - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

h. **Application of Ointments/Medications (Other Than to Feet)** - Includes ointments or medications used to treat a skin condition (e.g., cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (e.g., nitropaste for chest pain).

i. **Other Preventative or Protective Skin Care (Other Than to Feet)** - Includes application of creams or bath soaks to prevent dryness, scaling; application of protective elbow pads (e.g., down, padded, quilted).

j. ***NONE OF ABOVE***

Process: Review the resident's records. Ask the resident and nurse assistant.

Coding: Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*.

Clarifications:

◆ Good clinical practice dictates that staff should document treatments listed in MDS Item M5, Skin Treatments (e.g., turning and repositioning program; application of ointments) and MDS Item M6, Foot Problems and Care (e.g., trimming of nails/calluses; application of dressings). Flow sheets could be useful for this purpose, but the form and format of such documentation is determined by the facility.

◆ Dressings do not have to be applied daily in order to be coded on the MDS. If any dressing meeting the MDS definitions provided for MDS Items M5e-h was applied even once during the 7-day period, the assessor would check the appropriate MDS item.

M6. Foot Problems and Care (7-day look back)

Intent: To document the presence of foot problems and care to the feet during the last seven days.

Definition:

a. **Resident Has One or More Foot Problems (e.g., Corns, Callouses, Bunions, Hammer Toes, Overlapping Toes, Pain, Structural Problems** – includes ulcerated areas over plantar's warts on the foot.

b. **Infection of the Foot** – e.g., Cellulitis, Purulent Drainage

c. **Open Lesions On the Foot** - Includes cuts, ulcers, fissures.

d. **Nails or Callouses Trimmed During the Last 90 Days** - Pertains to care of the feet. Includes trimming by nurse or any health professional, including a podiatrist.

e. **Received Preventative or Protective Foot Care** - Includes any care given for the purpose of preventing skin problems on the feet, such as diabetic foot care, foot soaks, protective booties (e.g., down, sheepskin, padded, quilted), special shoes, orthotics, application of toe pads, toe separators, etc.

f. **Application of Dressings (With or Without Topical Medications)** - Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

g. ***NONE OF ABOVE***

Process: Ask the resident and nurse assistant. Inspect the resident's feet. Review the resident's clinical records.

Coding: Check all that apply. If none apply in the past seven days, check *NONE OF ABOVE*.

Clarification: ◆ For MDS coding, ankle problems are not considered foot problems and should NOT be coded in Item M6. Code in Item M5.

SECTION N. ACTIVITY PURSUIT PATTERNS

Intent: To record the amount and types of interests and activities that the resident currently pursues, as well as activities the resident would like to pursue that are not currently available at the facility.

Definition: **Activity Pursuits** - Refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. These include activities that provide increased self-esteem, pleasure, comfort, education, creativity, success, and financial or emotional independence.

N1. Time Awake (7-day look back)

Intent: To identify those periods of a typical day (over the last seven days) when the resident was awake all or most of the time, i.e., no more than a total of a one-hour nap during any such period. For care planning purposes this information can be used in at least two ways:

- The resident who is awake most of the time could be encouraged to become more mentally, physically, and/or socially involved in activities (solitary or group).
- The resident who naps a lot may be bored or depressed and could possibly benefit from greater activity involvement.

Process: Consult with direct care staff, the resident, and the resident's family.

Coding: Check all periods when resident was awake all or most of the time.

a. **Morning** - is from 7 a.m. (or when resident wakes up, if earlier or later than 7 a.m.) until noon.

b. **Afternoon** - is from noon to 5 p.m.

c. **Evening** - is from 5 p.m. to 10 p.m. (or bedtime, if earlier).

d. ***NONE OF ABOVE*** – If resident is comatose, code as "d", None of the Above, and skip all other Section N items on the MDS and go to Section O on the MDS.

Clarifications: ◆ When coding this item, check each time period, as defined for that resident, during which he or she did not nap for more than one hour. Some examples of coding are as follows:

- A resident wakes up every morning at 7 a.m. He typically eats breakfast, has a shower, gets dressed and goes back to bed for a late morning nap from 10 a.m. until 11:30 a.m. Item N1a (Morning) should NOT be checked, since this resident typically naps for more than 1 hour during the morning.
- A resident typically wakes up at 6 a.m. She is busy with therapy and activities most of the day, and does not take naps. She goes to bed by 7 p.m. every evening. Items N1a (Morning), N1b (Afternoon) and N1c (Evening) should all be checked, since this resident does not take naps.

- A resident who is bedfast and has end-stage Alzheimer's disease wakes up at 6 a.m. daily. She typically dozes off throughout the day, napping for more than 1 hour before noon, and again from 3:30 p.m. to 5:30 p.m. every afternoon. She is typically awake from 5:30 p.m. until 9 p.m. After that, she's asleep for the night. Items N1a (Morning) and N1b (Afternoon) should NOT be checked, since this resident naps for more than one hour during each of these periods. Item N1c (Evening) should be checked as time awake. Although this resident sleeps until 5:30 p.m., that is only a 30-minute nap time in the evening period.

◆ Accurate coding relies on the use of appropriate information-gathering techniques. Coding Items N1a, b, and c based on only the assessor's personal knowledge of a resident's typical day may result in an inaccurate response to this item. Documentation review is important. However, we would generally not expect facility staff to maintain flowcharts for information such as sleep and awake times.

◆ It is important to observe the resident across all shifts. In addition, the same individual staff member is generally not on duty and available to observe a resident across a 24-hour period. It's important to supplement observation with interviews of the resident, their family members, other staff across shifts, and in particular, the nursing assistants caring for the resident.

N2. Average Time Involved in Activities (7-day look back)

Intent: To determine the proportion of available time that the resident was actually involved in activity pursuits as an indication of his or her overall activity-involvement pattern. This time refers to free time when the resident was awake and was not involved in receiving nursing care, treatments, or engaged in ADL activities and could have been involved in activity pursuits and Therapeutic Recreation.

Definition: Include the amount of free time a resident has while awake and is not involved in receiving nursing care, treatments, or engaged in ADL activities. Examples of activity pursuits and therapeutic recreation of his/her choice could include watering plants; reading; letter-writing; social contacts/visits or phone calls from family, staff, and volunteers; recreational pursuits in a group, one-on-one or on an individual basis; and involvement in therapeutic recreation. Keep in mind that the definition of "activity pursuits" refers to any activity other than ADLs that a resident pursues in order to enhance a sense of well-being. Efforts should be made to provide activities suited to the resident's preferences and capabilities.

Activity staff should work with cognitively impaired residents to identify what types of activities are suitable. Some impaired persons prefer to walk through the corridors rather than engaging in a seated activity. Based on the resident's activity plan, certain activities, although not structured, may still be considered activities. The MDS Coordinator should work with the activities staff to determine which behaviors are considered appropriate activities for engaging the resident.

Many cognitively impaired persons continue to "pursue" their interests and also develop new interests. Activities must be tailored to their cognitive abilities. Record the amount of time the person spends in structured and non-structured activities.

Although dining is a social experience for some residents, and at times, meals may be planned around certain events or occasions, eating is not to be counted as an activity.

Process: Consult with direct care staff, activities staff members, the resident, and the resident's family. Ask about time involved in different activity pursuits.

Coding: In coding this item, exclude time spent in receiving treatments (e.g., medications, heat treatments, bandage changes, rehabilitation therapies, or ADLs). Include time spent in pursuing independent activities (e.g., watering plants, reading, letter-writing); social contacts (e.g., visits, phone calls) with family, other residents, staff, and volunteers; recreational pursuits in a group, one-on-one or an individual basis; and involvement in Therapeutic Recreation.

0. Most-More Than 2/3 of Time

1. Some-from 1/3 to 2/3 of Time

2. Little-Less Than 1/3 of Time

3. None

N3. Preferred Activity Settings (7-day look back)

Intent: To determine activity circumstances/settings that the resident prefers, including (though not limited to) circumstances in which the resident is at ease.

Process: Ask the resident, family, direct care staff, and activities staff about the resident's preferences. Staff's knowledge of observed behavior can be helpful, but only provides part of the answer. Do not limit the preference list to areas to which the resident now has access, but try to expand the range of possibilities for the resident.

> **Example**
>
> Ask the resident, "Do you like to go outdoors? Outside the facility (to a mall)? To events downstairs?" Ask staff members to identify settings that the resident frequents or where he or she appears to be most at ease.

Coding: Check all responses that apply. If the resident does not wish to be in any of these settings, check *NONE OF ABOVE*.

a. Own Room

b. Day/Activity Room

c. Inside NH/Off Unit

d. Outside Facility

e. *NONE OF ABOVE*

N4. General Activity Preferences (adapted to resident's current abilities) (7-day look back)

Intent: Determine which activities of those listed the resident would prefer to participate in (independently or with others). Choice should not be limited by whether or not the activity is currently available to the resident, or whether the resident currently engages in the activity or not.

Definition:

a. Cards/Other Games - Activities involving games, such as trivia games.

b. Crafts/Arts

c. Exercise/Sports - Includes any type of physical activity such as dancing, weight training, yoga, walking, sports (e.g., bowling, croquet, golf, or watching sports).

d. Music - Includes listening to music or being involved in making music (singing, playing piano, etc.)

e. Reading/Writing - Reading can be independent or done in a group setting where a leader reads aloud to the group or the group listens to "talking books." Writing can be solitary (e.g., letter-writing or poetry writing) or done as part of a group program (e.g., recording oral histories). Or a volunteer can record the thoughts of a blind, hemiplegic, or apraxic resident in a letter or journal.

f. **Spiritual/Religious Activities** - Includes participating in religious services as well as watching them on television or listening to them on the radio.

g. **Trips/Shopping**

h. **Walking/Wheeling Outdoors**

i. **Watching TV**

j. **Gardening or Plants** - Includes tending one's own or other plants, participating in garden club activities, regularly watching a television program or video about gardening.

k. **Talking or Conversing** - Includes social-type activities such as talking and listening to social conversations and discussions with family, friends, other residents, or staff. May occur individually, in groups, or on the telephone; may occur informally or in structured situations.

l. **Helping Others** - Includes helping other residents or staff, being a good listener, assisting with unit routines, etc.

m. ***NONE OF ABOVE***

Process: Consult with the resident, the resident's family, activities staff members, and nurse assistants. Explain to the resident that you are interested in hearing about what he or she likes to do or would be interested in trying. Remind the resident that a discussion of his or her likes and dislikes should not be limited by perception of current abilities or disabilities. Explain that many activity pursuits are adaptable to the resident's capabilities. For example, if a resident says that he used to love to read and misses it now that he is unable to see small print, explain about the availability of taped books or large print editions.

For residents with dementia or aphasia, ask family members about resident's former interests. A former love of music can be incorporated into the care plan (e.g., bedside audiotapes, sing-a-longs). Also observe the resident in current activities. If the resident appears content during an activity (e.g., smiling, clapping during a music program) check the item on the form.

Coding: Check each activity preferred. If none are preferred, check *NONE OF ABOVE*. Explore other possible sources of information, such as a responsible party that admitted the resident into the facility, or a surrogate decision maker who might know the resident's preferences. Is there any useful information in records that precede admission to the facility, such as hospital, community or home care records? If all resources are exhausted and you still do not have information,